DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT

NON-ROUTINE MEDICAL SURVEY

OF

KAISER FOUNDATION HEALTH PLAN, INC.

A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: APRIL 28, 2006
DATE ISSUED TO PUBLIC FILE: MAY 8, 2006

Final Report of a Non-Routine Medical Survey
Kaiser Foundation Health Plan, Inc.
A Full Service Health Plan

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducted a non-routine medical survey of Kaiser Foundation Health Plan, Inc. (the "Plan") pursuant to Section 1382(b) and Rule 1300.82.1(a) and (b)[1]. The Department notified the Plan in a letter dated November 18, 2005 of its intent to conduct a non-routine medical survey. The Department requested pre-on-site documentation from the Plan on November 28, 2005. The non-routine survey was conducted at the Plan's administrative office in Oakland, California on December 12-14, 2005.

The Department initiated this non-routine survey of the Plan for two reasons. First, over the past three to four years, the Department's HMO Help Center has evaluated a number of cases concerning the Plan's application of the "prudent layperson standard" in processing out-of-network emergency claims and noted a pattern in the number of previous decisions the Plan overturned once the enrollee complained to the Department.

Second, previous medical surveys suggest the Plan did not apply the "prudent layperson standard" until after the enrollee filed an appeal with the Plan. To further investigate the issue, the Department reviewed in-area, out-of-network emergency service appeals as part of the routine medical survey conducted in October and November 2005. Unfortunately, administrative delays and incomplete information resulted in an invalid file sample and invalid results. A non-routine survey was scheduled which afforded the Department an in-depth review of the Plan's system for processing in-area, out-of-network emergency service appeals.

The Preliminary Report of the survey findings was sent to the Plan on February 3, 2006. The Plan was required to submit a response to the Preliminary Report within 30 days of receipt of the Preliminary Report. The Plan submitted its response to the Department on March 8, 2006.

The Department found the corrective actions detailed by the Plan were non-responsive to the Preliminary Report. The Department held a meeting with Kaiser representatives on March 28, 2006 to discuss the Plan's response. This Final Report represents the Department's determination regarding the deficiencies identified during the non-routine survey, based on the Plan's submitted documents and additional discussions with Plan representatives.

A COPY OF THIS REPORT HAS BEEN REFERRED TO THE DEPARTMENT'S OFFICE OF ENFORCEMENT.

[1] References throughout this report to "Section ___" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as Amended [California Health and Safety Code Section 1340 *et seq*. ("the Act") References to "Rule ___" are to the regulations promulgated pursuant to the Act [Title 28 of the California Code of Regulations, beginning at Section 1300.43 and transferred to the Department of Managed Health Care pursuant to Health and Safety Code section 1341.14 ("the Rules")].

Survey Methodology

The non-routine survey was conducted to review, analyze, and evaluate the Plan's system for processing in-area, out-of-network emergency service appeals. The Department reviewed a random selection of 336 appeals files selected from the Plan's appeal log and Plan Regulatory complaint files. Information reviewed included, but was not limited to:

- Initial denial letters,
- Grievance resolution letters,
- Member appeal letters,
- Acknowledgement letters,
- Physician Review Form Commercial,
- Special Services Grievance Form,
- Case Summary Reports,
- System screen prints, and
- Emergency department medical records for the period January 1, 2004 through June 30, 2005.

During the on-site visit, the Department requested 61 additional files for review to assess the frequency of overturn decisions once the enrollee complained to the Department. File samples were taken from both Northern and Southern California operations.

Refer to Appendix A for a list of Department staff conducting this survey. Refer to Appendix B for a list of Plan officers and staff interviews. Refer to Appendix C for legal citations.

Survey Results

The Department identified six compliance deficiencies during this non-routine survey (see Section I. Table 1). The Plan has begun corrective actions to address these deficiencies; however, based on the Plan's response, the Plan requires a longer time to achieve full compliance. The Plan will confirm full compliance by July 31, 2006. Therefore, none of the deficiencies have been corrected as of the date of this report.

I. SURVEY DEFICIENCIES AND CORRECTIVE ACTIONS

Table 1 below lists deficiencies identified during the survey and the status of correction. Based on the preliminary report, the Plan was instructed to: (a) develop and implement a corrective action plan for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions.

TABLE 1

SUMMARY OF DEFICIENCIES		
#	**DEFICIENCY STATEMENT**	**STATUS**
GRIEVANCES AND APPEALS		
1	**When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to resolve appeals/grievances within 30 calendar days of receipt.** [Section 1368(a)(1) and Rule 1300.68(a)]	Not Corrected
2	**When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to acknowledge appeals/grievances within five calendar days of receipt.** [Section 1368(a)(4)(A) and Rule 1300.68(d)(1)]	Not Corrected
3	**When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to ensure adequate consideration of appeals/grievances.** [Section 1368(a)(1)]	Not Corrected
4	**When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to allow enrollees to submit appeals/grievances verbally.** [Section 1368(a)(1), Rule 1300.68(b)(1) and 1300.68(b)(4)]	Not Corrected
5	**When dealing with in-area, out-of-network emergency service appeals/grievances, the Plan repeatedly fails to pay for covered emergency services pursuant to the prudent layperson standard. The Plan also repeatedly fails to apply the prudent layperson standard pursuant to internal policies and procedures.** [Section 1371.4(c)]	Not Corrected
6	**When dealing with in-area, out-of-network emergency services, the Plan repeatedly applies a clinical standard not a "prudent layperson standard" until the enrollee appeals/grieves. The Plan is requiring the enrollee to utilize the appeals/grievance system to demonstrate to the Plan that he/she acted reasonably when seeking in-area, out-of-network emergency services.** [Sections 1367.01(b) and 1371.4(c)]	Not Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

GRIEVANCES AND APPEALS

Deficiency #1: **When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to resolve appeals/grievances within 30 calendar days of receipt.**

Documents Reviewed:
- 336 appeal files and 61 Plan Regulatory complaint files
- Commercial Grievance Process Policy and Procedures
- California Division Health Plan Clinical Review Department Policy and Procedures
- Complaint, Grievance and Appeals Process and Resolution Policy and Procedures
- Health Plan Clinical Review Appeals Process
- Health Plan Clinical Review Organization Chart

Criteria: Section 1368(a)(1) and Rule 1300.68(a)

Conditions: The Department reviewed 336 appeal files and 61 Regulatory complaint files. Out of the 397 files reviewed, 30 files contained resolution letters sent later than the 30 days after the Plan received the appeal.

Implications: Timely resolution of appeals is an essential component of a fair and effective grievance system.

Corrective Action: Pursuant to Rule 1300.80.10, the Plan is directed to submit evidence that it consistently resolves all appeals for in-area, out-of-network emergency services within 30 calendar days and provides the enrollee with a written resolution within the statutory requirements.

Plan's Compliance Effort: The Plan has undertaken a comprehensive review statewide of the existing hand-off procedures between the Member Services Department and the Claims Department. The Plan has identified opportunities to improve the process so that appeal/grievances are resolved and a written resolution is issued to the enrollee within the statutory time frames. (Note: A comprehensive description of the Plan's compliance effort is listed in Appendix D.)

The Plan Submitted the Following Documents:
- Commercial Grievance Process, Health Plan Clinical Review
- California Division Health Plan Clinical Review Department Policy and Procedure
- Oversight of Clinical Review Staff, Clinical Review Department
- N.E.D. Policy, Clinical Review Department
- Quality Improvement Policy and Procedure
- Pay Rules, Clinical Review

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds the deficiency has not been fully corrected. The Department found the Plan made a significant effort to address the deficiency. However, the Plan's corrective action plan set a date of July 31, 2006 to complete full implementation of corrective actions, demonstrating full compliance.

The Department found policy and procedure revisions incomplete. Policy review is suggested in the following areas:

- Monthly Grievance Audits, including validation of audit methodology
- Daily monitoring of open grievance cases by the Special Services Clinical Review Department

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Deficiency #2: **When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to acknowledge appeals/grievances within five calendar days of receipt.**

Documents Reviewed:
- 336 appeal files and 61 Plan Regulatory complaint files
- Commercial Grievance Process Policy and Procedures
- California Division Health Plan Clinical Review Department Policy and Procedures
- Complaint, Grievance and Appeals Process and Resolution Policy and Procedures
- Health Plan Clinical Review Appeals Process
- Health Plan Clinical Review Organization Chart

Criteria: Section 1368(a)(4)(A) and Rule 1300.68(d)(1)

Conditions: The Department reviewed 336 appeal files and 61 Regulatory complaint files. Out of the 397 files reviewed, 40 files contained acknowledgement letters sent later than five calendar days after the Plan received the appeal.

Implications: Timely acknowledgement of appeals is an essential component of a fair and effective grievance system.

Corrective Action: As referenced in Rule 1300.80.10, the Plan is directed to submit evidence that it consistently acknowledges all appeals for in-area, out-of-network emergency services within five calendar days of receipt.

Plan's Compliance Effort: The Plan has undertaken a comprehensive review statewide of the existing hand-off procedures between the Member Services Department and the Claims

Department and has identified opportunities to improve the process so that appeals/grievances are acknowledged with a letter to the enrollee within the statutory time frames. (Note: A comprehensive description of the Plan's compliance effort is listed in Appendix D.)

The Plan Submitted the Following Documents:
- Commercial Grievance Process, Health Plan Clinical Review
- California Division Health Plan Clinical Review Department Policy and Procedure
- Oversight of Clinical Review Staff, Clinical Review Department
- N.E.D. Policy, Clinical Review Department
- Quality Improvement Policy and Procedure
- Pay Rules, Clinical Review

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds this deficiency has not been fully corrected.

The Plan has begun a process improvement initiative to ensure appeals/grievances are acknowledged timely. The Plan states evidence will not be submitted to demonstrate compliance until July 31, 2006.

The Department found policy and procedure revisions incomplete. Policy review is suggested in the following areas:

- Monthly Grievance Audits, including validation of audit methodology
- Daily monitoring of open grievance cases by the Special Services Clinical Review Department

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Deficiency #3: **When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to ensure adequate consideration of appeals/grievances.**

Documents Reviewed:
- 336 appeal files and 61 Plan Regulatory complaint files
- Commercial Grievance Process Policy and Procedures
- California Division Health Plan Clinical Review Department Policy and Procedures
- Complaint, Grievance and Appeals Process and Resolution Policy and Procedures
- Health Plan Clinical Review Pay Determination Process
- Health Plan Clinical Review Appeals Process
- Health Plan Clinical Review Organization Chart
- Health Plan Auto Pay Catalog

Criteria: Section 1368(a)(1)

Conditions: The information commonly used in making initial payment decisions (e.g. medical records, triage notes, nurses notes, physicians dictated notes, diagnostic laboratory and radiology reports), was not reviewed by the Plan during the appeal/grievance review. Information in several files demonstrated the Plan waited until the enrollee complained to the Department to review the documents within the file.

Implications: A complete and thorough review of all available information is necessary in making the final determination of the appeals/grievances for in-area, out-of-network emergency services.

Corrective Action: As referenced in Rule 1300.80.10, the Plan is directed to submit evidence of a complete and accurate clinical review of claims for in-area, out-of-network emergency services during the initial claims review.

Plan's Compliance Effort: The Plan has begun a number of process changes to ensure complete review of claims for in-area, out-of-network emergency services during the initial claims process. (Note: A comprehensive description of the Plan's compliance effort is listed in Appendix D.)

The Plan Submitted the Following Documents:
- Commercial Grievance Process, Health Plan Clinical Review
- California Division Health Plan Clinical Review Department Policy and Procedure
- Oversight of Clinical Review Staff, Clinical Review Department
- N.E.D. Policy, Clinical Review Department
- Quality Improvement Policy and Procedure
- Pay Rules, Clinical Review

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds this deficiency has not been fully corrected. The Plan's full compliance is expected by July 31, 2006.

Deficiency #4: **When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to allow enrollees to submit appeals/grievances verbally.**

Documents Reviewed:
- 336 appeal files and 61 Plan Regulatory complaint files
- Commercial Grievance Process Policy and Procedures
- California Division Health Plan Clinical Review Department Policy and Procedures
- Complaint, Grievance and Appeals Process and Resolution Policy and Procedures

- Health Plan Clinical Review Appeals Process
- Health Plan Clinical Review Organization Chart
- Health Plan Appeals Intake Data, January 1, 2004 through June 30, 2005

Criteria: Section 1368(a)(1) and Rule 1300.68(b)(1) and 1300.68(b)(4)

Conditions:

- The Department conducted a series of follow-up telephone calls to the Plan's customer service 800 number to test the implementation of allowing enrollees to submit appeals/grievances verbally. The telephone calls were made between April 11 - 26, 2006. The following summarizes the conversations from each call placed by the Department.

Call Date	Results of Call
4/11/06	The Plan representative stated in-area, out-of-network emergency service appeals would need to be submitted in writing. The mailing address was provided.
4/14/06	The Plan representative stated in-area, out-of-network emergency service appeals would need to be submitted in writing. The mailing address was provided.
4/17/06	The Department notified the Plan representative that the telephone call was from the Department. The Plan representative consented to answer a few questions. The Department wanted to know if the Plan would accept a complaint, grievance or appeal verbally. The representative advised the Department to contact the facility where services were rendered but the complaint, grievance or appeal needed to be in writing. The next question from the Department "does the Plan have a policy and procedure for accepting complaints, grievances or appeals verbally. The response was no, the appeal needed to be submitted in writing.
4/18/06	The Department notified the Plan representative that the telephone call was from the Department. The Plan representative consented to answer a few questions. The Department wanted to know if the Plan has a policy and procedure that allows enrollees to submit complaints, grievances or appeals verbally. The Plan representative said yes that it was a new policy effective mid-March 2006.
4/18/06	The Plan representative stated in-area, out-of-network emergency service appeals would need to be submitted in writing or by fax. The mailing address and fax number was provided.
4/25/06	The Plan representative stated to appeal in-area, out-of-network emergency service to contact a different 800 number. The 800 number was provided.
4/26/06	The Department notified the Plan representative that the Department had a few questions regarding telephone call routing and accepting verbal grievances. ▪ Telephone Call Routing – The Plan representative advised if the telephone call originates from northern California, the call would be routed to the northern California call center. If the telephone call originates from southern California, the call would be routed to the southern California call center. ▪ Accepting Verbal Appeals/Grievances – The Plan representative advised the southern call center could accept verbal appeals/grievances and the northern call center could not.

- Of 397 files, all contained written enrollee appeal letters or faxes.
- The Plan's Intake Data for the period January 1, 2004 through June 30, 2005 showed a total of 1655 appeals of which 1646 appeals were in writing (includes letter, e-mail, fax and website), two were received by telephone and seven were received as walk ins.
- In 12 files, the enrollee referenced Plan instructions to submit the appeal in writing.
- In two files, the appeal letter referenced phone advice to the enrollee to submit the appeal in writing. File review documentation in one file shows system screen prints from the Member Integrated Tracking System where enrollee contacted the Plan to file an appeal and the Plan representative documented the following:

  "Dad stated his sons claim was denied and disputes the denial. I informed of the appeal process and gave the appeal address and fax #".
- In eight files, the Plan returned the appeal letter to the enrollee for signature stating, "Your signature was omitted in your appeal letter. Please sign the enclosed copy of your appeal letter and return it in the enclosed envelope."
- The Plan's initial denial letters to the enrollee provide appeal instructions; however, the language encourages the enrollee to submit the appeal in writing.
- The Plan's template letter under appeal rights states: "You or a representative that you formally designate has the right to dispute this decision. To do so, you or your designated representative **must submit an appeal in writing** (*emphasis added*), visit your local Health Plan Member Services office, or contact our Member Service Call Center at (telephone number given). You may submit written comments, documents, records and other information relating to your request for us to consider along with your written appeal". The letter also states, "Please submit your request and any materials you wish to be considered to the address or telephone number below."
- The Plan provides a mailing address and telephone number; however, the information that accompanies the telephone number states "If you have questions regarding this notice or your financial liability for denied charges, please contact our Member Service Department at (telephone number given)".

Implications: The ability to file a complaint or grievance with the Plan is the right of the enrollee. The Plan is required by law to accept telephonic grievances. The Plan's written grievance requirement is an operational barrier that impedes the enrollee's ability to state a concern, delays the resolution of the grievance, and may even discourage enrollees from submitting the grievance at all.

Corrective Action: As referenced in Rule 1300.80.10, the Plan is directed to demonstrate that it adheres to procedures allowing enrollees to file verbal appeals and grievances.

Plan's Compliance Effort: The Plan has begun a number of process improvements in the Member Service Departments, Northern California Call Center and Southern California Call Center, allowing enrollee's to submit grievances verbally. The Plan conducted a review of the Initial Denial Letter language and states in the section titled, "How to Dispute This

Determination" that enrollees may initiate the resolution process by either visiting the Health Plan Member Service Departments, or by contacting the Member Service Call Center by telephone or through the Plan's website. (Note: A comprehensive description of the Plan's compliance effort is listed in Appendix D.)

The Plan Submitted the Following Documents:

- Commercial Grievance Process, Health Plan Clinical Review
- California Division Health Plan Clinical Review Department Policy and Procedure
- Oversight of Clinical Review Staff, Clinical Review Department
- N.E.D. Policy, Clinical Review Department
- Quality Improvement Policy and Procedure
- Pay Rules, Clinical Review

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds this deficiency has not been fully corrected.

The Plan has initiated a number of process changes to ensure acceptance of verbal appeals/grievances at each California Call Center. Changes began March 15, 2006. The Plan will demonstrate full compliance by July 31, 2006.

The Department found incomplete document submissions and revisions. Document review is suggested in the following areas in accordance with the Plan's corrective actions:

- Plan's Commercial Grievance Process policy and procedures, specifically, "A grievance should be (*emphasis added.)* submitted in written form, usually by letter or a Statement of Emergency."
- Initial Denial Letter, the language remains unclear. Language could mislead enrollees. "Your Appeal Rights" section, enrollees or a designated representative, "must submit an appeal in writing, visit your local Health Plan Member Services office, or contact Member Service Call Center at" (phone number provided).
- Policy and procedures for the Member Services Department, Northern California Call Center and Southern California Call Center.
- Training procedures and mechanisms to audit and confirm process changes during change implementation.

Deficiency #5: **When dealing with in-area, out-of-network emergency service appeals/grievances, the Plan repeatedly fails to pay for covered emergency services pursuant to the prudent layperson standard. The Plan also repeatedly fails to apply the prudent layperson standard pursuant to internal policies and procedures.**

Documents Reviewed:

- 336 appeal files and 61 Plan Regulatory complaint files
- Commercial Grievance Process Policy and Procedures
- California Division Health Plan Clinical Review Department Policy and Procedures
- Complaint, Grievance and Appeals Process and Resolution Policy and Procedures

Criteria: Section 1371.4(c)

Conditions:

- The Plan fails to pay for covered services, in cases where a Plan representative directed the enrollee to proceed to the nearest emergency department.
- The Plans policy, "Health Plan Clinical Review, Commercial Grievance Process," effective 11/10/96, revised 03/30/05, states on Page 3:

  "Directed Care: If a member is directed to care out of Plan by an authorized representative of the Health Plan, Medical Groups, or Hospital, that will be considered as an authorization for the emergency evaluation and treatment".
- The Department conducted interviews on December 14, 2005 in which the Plan reported operational gaps with internal systems. The Advice Log and the Member Service tape of calls were not available to the Medical Director or the Grievance Unit.
- In documentation evidenced in file review, 59 enrollee appeal letters stated the enrollee contacted the Plan and obtained authorization to access emergency care out-of-network.
- In documentation evidenced in file review, two files indicated that a Plan advice nurse directed the enrollee to seek emergency care out of network. However, the advice nurse failed to document the authorization in the system call log notes. Upon further investigation by the Plan and after the appeal was denied and the enrollee filed a complaint with the Department, the audio tape transcriptions were located by the Plan, which clearly instructed the enrollee to in-area, out-of-network emergency services.

Implications: Once a Plan representative authorizes or directs care, the enrollee relies in good faith on that direction to access in-area, out-of-network emergency services. The failure of Plan representatives to document the authorization, or to review the audiotapes, negatively impacts the processing of claims and resolution of appeals/grievances and puts the enrollee at financial risk. Moreover, the enrollee's health could be jeopardized if they are now reluctant to follow the instructions of the advice nurse in subsequent encounters, knowing the Plan will deny the claim if they proceed to an out-of-network emergency department as instructed.

Corrective Action: Pursuant to Rule 1300.80.10, the Plan is directed to revise policies and procedures to ensure thorough investigation and location of authorizations or referrals made by Plan representatives directing enrollees to access in-area, out-of-network emergency services.

Plan's Compliance Effort: The Plan is implementing new policies and procedures to ensure Plan staff thoroughly investigate the existence of authorizations or referrals issued to enrollee's by Plan representatives. (Note: A comprehensive description of the Plan's compliance effort is listed in Appendix D.)

The Plan Submitted the Following Documents:

- Commercial Grievance Process, Health Plan Clinical Review
- California Division Health Plan Clinical Review Department Policy and Procedure
- Oversight of Clinical Review Staff, Clinical Review Department
- N.E.D. Policy, Clinical Review Department
- Quality Improvement Policy and Procedure
- Pay Rules, Clinical Review

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds this deficiency has not been fully corrected.

Implementation of new policy and evidence of compliance will be submitted by July 31, 2006.

Deficiency #6: **When dealing with in-area, out-of-network emergency services, the Plan repeatedly applies a clinical standard not a "prudent layperson standard" until the enrollee appeals/grieves. The Plan is requiring the enrollee to utilize the appeals/grievance system to demonstrate to the Plan that s/he acted reasonably when seeking in-area, out-of-network emergency services.**

Documents Reviewed:

- 336 appeal files and 61 Plan Regulatory complaint files
- Commercial Grievance Process Policy and Procedures
- California Division Health Plan Clinical Review Department Policy and Procedures
- Complaint, Grievance and Appeals Process and Resolution Policy and Procedures
- Health Plan Clinical Review Pay Determination Process
- Health Plan Auto Pay Catalog

Criteria: Sections 1367.01(b) and 1371.4(c)

Conditions:

- The Plan applies a clinical standard and fails to give adequate consideration to whether the enrollee acted in accordance with the prudent layperson standard, thereby forcing the enrollee to submit an appeal/grievance or complaint to the Department in order to obtain payment of the claim.
- The Plan reported a high denial overturn rate, approximately 50%, if the enrollee submitted an appeal. This suggests the Plan did not have adequate information to make the correct decision during the initial review.

- Of 61 regulatory complaints, 29 approved by the Plan's Regulatory Department citing a "prudent layperson" standard.
- Of 336 appeals, 38 approved as "prudent layperson" during the enrollee grievance process.
- In the majority of cases, the Plan overturns the initial denial based on, "additional information from the member."
- Plan staff confirmed reliance on enrollee's appeal letter to "tell the whole story," giving reasons why they accessed out-of-network emergency room services. This allowed Plan staff, "to get inside the member's head."
- Statements made by Plan staff suggested a need for written information from the enrollee to determine whether the enrollee acted prudently. This evidence suggests application of the "prudent layperson standard" occurs, only if the member submits an appeal.
- The file review and statements made by Plan staff confirm that at the claim review level, the Plan's practice is to solicit additional clinical information from the treating emergency department or provider, or to review the members recent clinical history, but at no time during this review is the enrollee contacted or asked to provide information.
- Staff comments during interviews on December 14, 2005 indicate the entire case is reviewed by the Plan once the enrollee complains to the Department. The "whole" picture is subject to review by staff, laypeople and clinical review.
- Staff comments during interviews on December 14, 2005 indicate the Plan utilizes clinical criteria to determine whether or not a member acted prudently in seeking in-area, out-of-network emergency services, however, criteria are not in writing.
- The Plan letters to the Department indicate that previous grievance determinations are overturned due to the Plan's application of the "prudent layperson" standard, suggesting this standard had not been applied until the enrollee complained to the Department. The Department reviewed the cases with the Plan on December 14, 2005.

Implications: The standard of review requires an interpretation based on the circumstances whether a reasonable person would consider it necessary to seek emergency services for a particular medical condition. Placing responsibility on the enrollee to demonstrate he/she acted reasonably or applying a clinical standard in evaluating the enrollee's experience serves to confuse and misapply the standard.

Corrective Action: As referenced in Rule 1300.80.10, the Plan is directed to submit evidence of consistent application of the "prudent layperson standard" during initial claims review pursuant to Rule 1371.4(c).

Plan's Compliance Effort: The Plan submitted revised policies and procedures changing the "prudent layperson standard" to "Emergency Medical Condition". (Note: A comprehensive description of the Plan's compliance effort is listed in Appendix D.)

The Plan Submitted the Following Documents:

- Commercial Grievance Process, Health Plan Clinical Review
- California Division Health Plan Clinical Review Department Policy and Procedure
- Oversight of Clinical Review Staff, Clinical Review Department
- N.E.D. Policy, Clinical Review Department
- Quality Improvement Policy and Procedure
- Pay Rules, Clinical Review

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds the Plan's corrective action plan non-responsive to this deficiency.

A revised corrective action plan is required within 30 days of the issuance of this report. The elimination of the prudent layperson standard of review in the Plan's policies and procedures was a change that minimized the enrollee experience in determining claims payment. Therefore, the response was not adequate and compliance cannot be determined.

II. SURVEY CONCLUSION

The Department has completed a non-routine survey of in-area, out-of-network emergency claims review for the Plan. The Department will conduct a follow-up review in six months from the Final Report's issue date. At that time, the Department will validate the correction of all cited deficiencies.

A P P E N D I X A

A. LIST OF SURVEYORS

The Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Ann Vuletich	Staff Health Plan Analyst – Team Leader
Roxann Floyd	Staff Health Plan Analyst
Marilou Lasam	Staff Health Plan Analyst
Debra L. Denton	Assistant Chief Counsel, Office of Enforcement
Andrew George	Staff Counsel, HMO Help Center
Laura Plummer	Nurse Consultant, HMO Help Center

A P P E N D I X B

B. LIST OF STAFF INTERVIEWED

The following are the key Plan officers and staff who were interviewed during the on-site survey at the Plan.

Dr. Bruce Locke	Medical Director, Clinical Review
Sheila Tucker	Director, Clinical Review
Martha Sikkens	Director, Survey Readiness, Health Plan Regulatory Services
Elizabeth Moorehead	Director, Regulatory Compliance for California Claims Administration
Daniel Chesir	Manager, Regulatory Investigation and Regulatory Response
Susan McGee	Managing Director, Regulatory Response, Health Plan Regulatory Services
Christie Larner	Director, Regulatory Investigation and Regulatory Response
Lateefah Herron	Lead Examiner, NCAL Claims Department
Debbie Galan	Medical Audit Supervisor, Clinical Review

A P P E N D I X C

C. APPLICABLE STATUTES AND REGULATIONS

The following are the specific citations used in this report as the basis for the deficiencies.

GRIEVANCES and APPEALS

Deficiency #1: **When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to resolve appeals/grievances within 30 calendar days of receipt.** [Section 1368(a)(1) and Rule 1300.68(a)]

Citations:

Section 1368(a)(1)

Every Plan shall do all of the following:
Establish and maintain a grievance system approved by the Department under which enrollees may submit their grievances to the Plan. Each system shall provide reasonable procedures in accordance with Department regulations that shall ensure adequate consideration

Rule 1300.68(a)

The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system.

Deficiency #2: **When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to acknowledge appeals/grievances within five calendar days of receipt.** [Section 1368(a)(4)(A) and Rule 1300.68(d)(1)]

Citations:

Section 1368(a)(4)(A)

Every plan shall do all of the following:
Provide for a written acknowledgment within five calendar days of receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:
(i) That the grievance has been received.
(ii) The date of receipt.
(iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

Rule 1300.68(d)(1)

The plan shall respond to grievances as follows:
A grievance system shall provide for a written acknowledgement within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant

that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance.

Deficiency #3: **When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to ensure adequate consideration of appeals/grievances.** [Section 1368(a)(1)]

Citation:
Section 1368(a)(1)
Every plan shall do the following:
Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Deficiency #4: **When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to allow enrollees to submit appeals/grievances verbally.** [Section 1368(a)(1) and Rule 1300.68(b)(1) and 1300.68(b)(4)]

Citations:
Section 1368(a)(1)
Every plan shall do the following:
Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Rule 1300.68(b)(1)
The Plan's grievance system shall include the following:
An officer of the Plan shall be designated as having primary responsibility for the Plan's grievance system whether administered directly by the Plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

Rule 1300.68(b)(4)
The Plan's grievance system shall include the following:
The Plan shall maintain a roll-free number, or a local telephone number in each service are, for the filing of grievances.

Deficiency #5: **When dealing with in-area, out-of-network emergency service appeals/grievances, the Plan repeatedly fails to pay for covered emergency services pursuant to the prudent layperson standard. The Plan also repeatedly fails to apply the prudent layperson standard pursuant to internal policies and procedures.** [Section 1371.4(c)]

Citation:

Section 1371.4(c)

Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

Deficiency #6: **When dealing with in-area, out-of-network emergency services, the Plan repeatedly applies a clinical standard not a "prudent layperson standard" until the enrollee appeals/grieves. The Plan is requiring the enrollee to utilize the appeals/grievance system to demonstrate to the Plan that he/she acted reasonably when seeking services.** [Sections 1367.01(b) and 1371.4(c)]

Citations:

Section 1367.01(b)

A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays or denies, based in whole or in part on medical necessity, requests by providers of health care services for Plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modified, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision for health care services to enrollees, shall be filed with the Director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the Plan to the public upon request.

Section 1371.4(c)

Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service

plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

A P P E N D I X D

D. DETAILED CORRECTIVE ACTION PLAN

DMHC Identified Deficiency	DMHC Required Corrective Action	KFHP Response (a) Include name(s) and title(s) of person(s) who will be responsible for implementing CAP b) a time schedule for implementing CAP c) Documents or evidence that the deficiency has been corrected)
Deficiency I When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to resolve appeals/grievances within 30 calendar days of receipt (Section 1368 (a)(1) and Rule 1300.68(a)	Deficiency I As referenced in Rule 1300.80.10, the Plan is directed to submit evidence that it consistently resolves all appeals for in-area, out-of-network emergency services within 30 calendar days and provides enrollee with a written resolution within the statutory requirements.	Deficiency I By July 31, 2006, the Plan will submit evidence that will demonstrate that we consistently resolve all appeals for in-area, out-of-network emergency services within 30 calendar days and provide the enrollee with a written resolution within the statutory requirements. A comprehensive review of our existing hand-off process between our Member Services Department and the Claims Department statewide identified the following opportunity to improve the process such that consistently claims appeals/grievances are resolved and a written resolution is issued within 30 calendar days. The process improvement is described below: Member Services: Effective March 15, 2006, the current hand-off process for claims appeals/grievances received by Member Services will be changed from a paper process to an electronic process. Below is a description of the electronic process: • The service representatives at the Member Services offices statewide will take the grievance from the member in person or by telephone. The Member Service representative will: • Record all information regarding the grievance in the Member Contact Tracking System (MCTS), using the date of the in person or telephonic contact

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		with the member as the grievance received date. Member Services will immediately forward the grievance case electronically via MCTS to Special Services Clinical Review. • MCTS will retain the received date that was initially entered for the case. • The Member Service representative will immediately forward the case electronically via MCTS to Special Services Clinical Review. • Special Services Clinical Review will receive the grievance via MCTS and will begin to process the case. <u>Claims Administration:</u> Effective March 15, 2006, The California Claims (CCA) statewide will implement a comprehensive review of all written correspondence within 24 hours of receipt. Correspondence from members involving a claims grievance will be forwarded the same day to Special Services Clinical Review for processing. The CCA designated staff will be in-serviced on the revised process by March 13, 2006. • To ensure that appeals/grievance cases are being handled within the required timeframes, open cases will be monitored daily. The manager/supervisor of Special Services Clinical Review will be responsible for monitoring open grievance cases on a daily basis, utilizing a daily aging report from MCTS. The manager/supervisor will work with the staff assigned to the open cases to ensure that acknowledgement letters are sent on cases that are 3 days old and resolution letters are sent on cases that are 25 days old. The CCA Regulatory Compliance Team will meet with the manager of Special Services Clinical Review on a weekly and monthly basis to review the weekly and monthly timeliness performance. • The management team in Special Services Clinical Review will continue to conduct monthly audits of a random sample of completed grievance cases.

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		The CCA Compliance Team will validate the audit methodology and results. The audit results will be tracked, trended and reported to the monthly compliance meetings and quarterly claims executive review meeting. <u>Responsible Party:</u> • Elizabeth Moorehead (Director of Regulatory Compliance, CCA) • Sheila Tucker (Director of Clinical Review, CCA) • Lydia Sweatt (Manager of Special Services Clinical Review, CCA) • Jeff Dankwerth (Leader, NCAL Claims) • Kimberly D Stone (Manager, SCAL Claims Operations) • Regional Director of Member Services, NCAL • Regional Director of Member Services, SCAL

DMHC Identified Deficiency	DMHC Required Corrective Action	KFHP Response (a) Include name(s) and title(s) of person(s) who will be responsible for implementing CAP b) a time schedule for implementing CAP c) Documents or evidence that the deficiency has been corrected)
<u>Deficiency 2</u> When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to acknowledge appeals/appeals within five calendar days of	<u>Deficiency 2</u> As referenced in Rule 1300.80.10, the Plan is directed to submit evidence that it consistently acknowledges all appeals for in-area.	<u>Deficiency 2</u> By July 31, 2006, the Plan will submit evidence that will demonstrate that the Plan consistently acknowledges all appeals for in-area, out-of-network emergency services within five (5) calendar days of receipt. A comprehensive review of our existing hand-off process between our Member Services Department and the Claims Department statewide identified the following opportunity to improve the process so that consistently

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receipt (Section 1368 (a)(4)(A) and Rule 1300.68(a)	out-of-network emergency services within five (5) calendar days after the Plan received the appeal.	claims appeals/grievances are acknowledged within five (5) calendar days of receipt. The process improvement are described below: <u>Member Services:</u> Effective March 15, 2006, the current hand-off process for claims appeals/grievances received by Member Services will be changed from a paper process to an electronic process. Below is a description of the electronic process: • The service representatives at the Member Services offices statewide will take the grievance from the member in person or by telephone. The Member Service representative will: • Record all information regarding the grievance in the Member Contact Tracking System (MCTS), using the date of the in person or telephonic contact with the member as the grievance received date. Member Services will immediately forward the grievance case electronically via MCTS to Special Services Clinical Review. • MCTS will retain the received date that was initially entered for the case. • The Member Service representative will immediately forward the case electronically via MCTS to Special Services Clinical Review. • Special Services Clinical Review will receive the grievance via MCTS and will begin to process the case. <u>Claims Administration:</u> Effective March 15, 2006, The California Claims (CCA) statewide will implement a comprehensive review of all written correspondence within 24 hours of receipt. Correspondence from members involving a claims grievance will be forwarded the same day to Special Services Clinical Review for processing. The CCA designated staff will be in-serviced on the revised process by March 13, 2006.

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		• To ensure that appeals/grievance cases are being handled within the required timeframes, open cases will be monitored daily. The manager/supervisor of Special Services Clinical Review will be responsible for monitoring open grievance cases on a daily basis, utilizing a daily aging report from MCTS. The manager/supervisor will work with the staff assigned to the open cases to ensure that acknowledgement letters are sent on cases that are 3 days old and resolution letters are sent on cases that are 25 days old. The CCA Regulatory Compliance Team will meet with the manager of Special Services Clinical Review on a weekly and monthly basis to review the weekly and monthly timeliness performance. • The management team in Special Services Clinical Review will continue to conduct monthly audits of a random sample of completed grievance cases. The CCA Compliance Team will validate the audit methodology and results. The audit results will be tracked, trended and reported to the monthly compliance meetings and quarterly claims executive review meeting. <u>Responsible Party:</u> • Elizabeth Moorehead (Director of Regulatory Compliance, CCA) • Sheila Tucker (Director of Clinical Review, CCA) • Lydia Sweatt (Manager of Special Services Clinical Review, CCA) • Jeff Dankwerth (Leader, NCAL Claims) • Kimberly D Stone (Manager, SCAL Claims Operations) • Regional Director of Member Services, NCAL • Regional Director of Member Services, SCAL

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Deficiency 3 When dealing with in-area, out-of-network emergency services, the Plan repeatedly fails to ensure adequate consideration of appeals/grievances. (Section 1368(a)(1)	Deficiency 3 As referenced in Rule 1300.80.10, the Plan is directed to submit evidence that it consistently conducts complete and accurate clinical reviews of claims for in-area, out-of-network emergency services during the initial claims review.	Deficiency 3 By July 31, the Plan will submit evidence to demonstrate that we consistently conduct complete and accurate clinical reviews of claims for in-area, out-of-network emergency services during the initial claims review. The following process changes will be implemented to provide the opportunity demonstrate that a consistent, complete and accurate review is conducted during the initial claims review: • The Clinical Review policies and procedures, titled "California Division Health Plan Clinical Review Department, Policies and Procedures, Section C titled "Documentation for Clinical Review of Claims," and Section D titled "Review of Claims for Benefit Interpretation" for the initial review of claims were revised on February 20, 2006 to include a specific list of documentation that must be reviewed before a decision can be made. (Attachment, "California Division Health Plan Clinical Review Department Policies and Procedures.") • To demonstrate that the required documentation is consistently obtained and forwarded to the physician for the review of claims for out-of-network emergency services, a checklist has been added to the Physician Review form that will allow the physician to indicate the specific type(s) of documentation that he/she reviewed during the initial review of the claim. The addition of the checklist will effectively demonstrate and document that the required documentation is reviewed on a consistent basis for every out-of-network emergency services claim. The revised Physician Review form, with the added checklist, will be implemented on March 15, 2006. Training for the staff is scheduled on March 8, 2006. (Attachment, "Physician Review Form Commercial") • The monthly grievance overturn report will be jointly reviewed by the

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		management team in Clinical Review, Health Plan Regulatory Services Investigation and Response Unit and the CCA Compliance Team. Analysis will be conducted to determine the specific reason(s) for the overturned grievance cases. The results of the analysis will be tracked and trended to identify opportunities for improvement and will be reported to the members of the monthly compliance meetings and the quarterly claims executive review meeting. <u>Responsible Party:</u> • Elizabeth Moorehead (Director of Regulatory Compliance, CCA) • Sheila Tucker (Director of Clinical Review, CCA) • Lydia Sweatt (Manager of Special Services Clinical Review, CCA) • Bruce Locke, MD (Medical Director, Clinical Review) • Christie Larner, (Director Health Plan Regulatory Investigations and Response

DMHC Identified Deficiency	DMHC Required Corrective Action	KFHP Response (a) Include name(s) and title(s) of person(s) who will be responsible for implementing CAP b) a time schedule for implementing CAP c) Documents or evidence that the deficiency has been corrected)
<u>Deficiency 4</u> When dealing with in-area, out-of-network emergency services, the Plan repeatedly	<u>Deficiency 4</u> As referenced in Rule 1300.80.10, the Plan is directed demonstrate that it adheres to its	<u>Deficiency 4</u> <u>T</u>he Plan's Policies and Procedures state that enrollees can file appeals/grievances by visiting the Health Plan Member Services office at the local Kaiser Permanente facility, or by contacting the Member Service Call Center at (1-800-464-4000), or by submitting a request in

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fails allow enrollees to submit appeals/grievances verbally. (Section 1368(a)(1) and Rule 1300.68(b)(1) and 1300.68(b)(4)	policies and procedures to allow enrollees to file appeals and grievances verbally.	writing or though our Web site at ww.members.kp.org. The practice of accepting appeals/grievances verbally is in place in departments within the Plan. By July 31, 2006, the Plan will submit evidence to demonstrate that for claim appeals the Plan adhere to its policies and procedures to allow enrollees to file appeals and grievances verbally. Review of the filing process for claim appeals identified an opportunity to implement new policies and procedures that will provide that verbal appeals/'grievances are managed in accordance with policy when received at our Call Centers. In addition, the hand-off process for appeals/grievances received at our Member Services offices will be changed from a paper process to an electronic process. The following process improvements will be implemented: <u>Member Services:</u> Effective March 15, 2006, service representatives at the Member Services offices statewide will take the grievance from the member in person or by telephone. The Member Service representative will: • Record all information regarding the grievance in the Member Contact Tracking System (MCTS), using the date of the in person or telephonic contact with the member as the grievance received date. Member Services will immediately forward the grievance case electronically via MCTS to Special Services Clinical Review • MCTS will retain the received date that was initially entered for the case • The Member Service representative will immediately forward the case electronically via MCTS to Special Services Clinical Review • Special Services Clinical Review will receive the grievance via MCTS.

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		NCAL Call Center: The NCAL Center will transfer calls received from members who are appealing a denied or a partially paid claim for out-of-network emergency services to Special Services Clinical Review. To provide a smooth transition, implementation will occur in three phases: • Phase I: Currently, there are two Claims Queue Teams at the Call Center. Beginning March 15, 2006, calls from members regarding a claims grievance received through one of the Claims Queue Teams during business hours will be transferred to a dedicated line in Special Services Clinical Review for processing. The call volume from the first Claims Queue Team represents approximately 30% of the overall volume. This phase will serve as our "pilot" phase and will provide a better understanding of the call volume that must be handled by Special Services Clinical Review upon completion of all phases of the implementation. An understanding of the call volume will allow the Plan to make required adjustments to the staffing levels to ensure that calls are handled timely. • Phase II: Beginning March 22, 2006, calls from members regarding a claims grievance received through the remaining Claims Queue Team during business hours will be transferred to a dedicated line in Special Services Clinical Review for processing. The call volume from the Claims Queue Teams represents approximately 80% of the overall volume. • Phase III: The remaining volume of calls, received on weekdays from 7am to 8am, 5pm and 7pm and on Saturdays from 7am to 3pm, will be transferred to the dedicated line in Special Services Clinical Review beginning April 1, 2006. Initially, calls received on weekdays from 7am to 8am, 5pm to 7pm and on

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		Saturdays from 7am to 3pm will be transferred to a recording where the member can leave a message. The Special Service Clinical Review staff will contact the member the next business day following receipt of the message to obtain further information concerning the grievance. The date of member's initial contact will be recorded as the date when the grievance was received by the Plan. The Manager of Special Services Clinical Review will track and trend the daily call volumes to determine if changes to the staff schedule is necessary to effectively handle the call volume received after business hours. Staffing levels and schedules may be adjusted based on the outcomes of the call volume analysis. <u>SCAL Call Center:</u> Initially, calls received from members who are appealing a denied or partially paid claim for out-of-network emergency services will be transferred to Special Services Clinical Review. The process will be further enhanced at a later date to send the appeal/grievance electronically to Special Services Clinical Review. To provide a smooth transition, implementation will occur in two phases: • <u>Phase 1</u>: Beginning April 1, 2006, calls from members regarding a claims grievance received through the Claims Queue Teams will be transferred to a dedicated line in Special Services Clinical Review for processing. The business hours for the Claims Queue Team are 8am-5pm Monday to Friday. The call volume from the Claims Queue Team represents approximately 80% of the overall volume. The remaining volume of calls, received on weekdays from 7am to 8am, 5pm and 7pm and on Saturdays from 7am to 3pm, will be transferred to will be transferred to a recording where the member can leave a message. The Special Service Clinical Review staff will contact the member the next business day following receipt of the message to obtain further information concerning the grievance. The date of member's initial contact

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		will be recorded as the date when the grievance was received by the Plan. The Manager of Special Services Clinical Review will track and trend the daily call volumes to determine if changes to the staff schedule is necessary to effectively handle the call volume received after business hours. Staffing levels and schedules may be adjusted based on the outcomes of the call volume analysis. • Phase II: Beginning April 17, 2006, all calls will be handled as follows: o The Call Center Customer Service Representative will record all information regarding the grievance in the Vantive System. o The Vantive system entry will be immediately downloaded to the Member Contact Tracking System (MCTS). The case will be electronically sent to Special Services Clinical Review. The date of the in person or telephonic contact with the member will be used as the received date of he grievance. o Special Services will begin to process the case. • In May 2006, the Clinical Review and Call Center management teams will conduct a post implementation analysis that will be used to identify opportunities for process improvement. Results of the analysis, as well as implementation of process improvements, will be reported to the members of the monthly compliance meetings and the quarterly executive claims review meeting. • The Plan completed a thorough review of our initial denial letters. Our review revealed that the current initial denial letter states in the section titled, "How to Dispute This Determination," that our members may initiate our resolution process by either visiting the Health Plan Member Services office at the local

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		Kaiser Permanente facility, or by contacting the Member Service Call Center at (1-800-464-4000) or though our Web site at www.members.kp.org. The language used in our denial letters provides our members with the other available options that may used to file an appeal in addition to submitting an appeal in writing. <u>Responsible Party:</u> • Elizabeth Moorehead (Director of Regulatory Compliance, CCA) • Sheila Tucker (Director of Clinical Review, CCA) • Lydia Sweatt (Manager of Special Services Clinical Review, CCA) • Jeff Dankwerth (Leader, NCAL Claims) • Kimberly D Stone (Manager, SCAL Claims Operations) • Regional Director of Member Services, NCAL • Regional Director of Member Services, SCAL • Kay McManus (Manager Regulatory Compliance, Call Centers)

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<u>Deficiency 5</u> When dealing with in-area, out-of-network emergency service appeals/grievances, the Plan repeatedly fails to	<u>Deficiency 5</u> As referenced in Rule 1400.80.10, the Plan is directed to revise its policies	<u>Deficiency 5</u> By July 31, 2006, the Plan will submit evidence to demonstrate that new policies and procedures were implemented to ensure that Plan staff thoroughly investigates the existence of any authorizations or referral by the Plan for an enrollee to access in-area, out-of-network emergency services.

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pay for covered emergency services pursuant to the prudent layperson standard. The Plan also repeatedly fails to apply the prudent layperson standard pursuant to internal policies and procedures. (Section 1371.4(c)	and procedures to require Plan staff to thoroughly investigate the existence of any authorizations or referrals by the Plan for an enrollee to access in-area, out-of-network emergency services.	The following changes noted in the policies will be implemented to the existing investigation process in Special Services Clinical Review to determine if any authorizations or referrals by the Plan exist. Below is a description of the process changes: • The policies and procedures for claims grievance, titled "Health Plan Clinical Review, Commercial Grievance Process," were revised on February 20, 2006 to state that when a member appeal/grievance is received and the member states that he/she was directed by a KP representative to access out-of-plan care, the staff in Special Services Clinical Review will: o Check the advice log system. o If the advice log system does not contain information that the member contacted the Plan and was directed to receive out of plan care, the Special Services staff will contact the member by phone to obtain additional information to determine what phone number the member called and what specific directions the member was given by the Plan representative. o If the information on the advice log system is different from the member's statement, the Special Services staff will obtain a transcription of the taped conversation between the member and the Plan representative. o The advice log will be attached to the physician review packet along with the transcript notes, and will be scanned into the I-file system when the appeal/grievance review is complete. The staff will be in-serviced on the policy and procedures by March 15, 2006.

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		• The Medical Director of Clinical Review, Director of Clinical Review and the Director of Health Plan Regulatory Services Investigation and Response Unit will work with the management team responsible for the Advice log staff to discuss the importance of consistent and accurate documentation of information on the advice log systems. Inconsistent system entries that are identified during the review of grievance cases will be tracked, trended and analyzed by the Special Services Clinical Review management team. The results of this analysis will be discussed with the management of the Advice Log staff on at least a quarterly basis to identify opportunities for process improvement. The first meeting is scheduled for March 15, 2006. • The management team in Special Services Clinical Review will continue to conduct monthly audits of a random sample of completed grievance cases. The CCA Compliance Team will validate the audit methodology and results. The audit results will be tracked, trended and reported to the monthly compliance meetings and quarterly claims executive review meeting. <u>Responsible Party:</u> • Elizabeth Moorehead (Director of Regulatory Compliance, CCA) • Sheila Tucker (Director of Clinical Review) • Lydia Sweatt (Manager of Special Services Clinical Review) • Bruce Locke, MD (Medical Director, Clinical Review) • Christie Larner (Director, Regulatory Investigation and Response Health Plan Regulatory Services)

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Deficiency 6 When dealing with in-area, out-of-network emergency services, the Plan repeatedly applies a clinical standard not a "prudent layperson standard" until the enrollee appeals/grieves. The Plan is requiring the enrollee to utilize the appeals/grievance system to demonstrate to the Plan that s/he acted reasonably when seeking in-area, out-of-network emergency services. (Sections 1367.01(b) and 1371.4(c)	Deficiency 6 As referenced in Rule 1300.80.10, the Plan is directed to submit evidence that it consistently applies "prudent layperson standards" at the initial claims review level as required under Rule 1371.4(c)	Deficiency 6 By July 31, 2006, the Plan will submit evidence that we consistently apply the Emergency Medical Condition standards at the initial claims review level. The Plan has identified the following opportunities to improve the process of consistently applying the Emergency Medical Condition standard at the initial claims review. • The Clinical Review policies and procedures include a comprehensive list of processes that are being utilized during the initial review of a claim to ensure that a consistent approach is followed in the determination of an Emergency Medical Condition. To further improve our process, The Clinical Review policies and procedures, titled "Policies and Procedures Clinical Review Department, Clinical Review of Claims," for the initial review of claims were revised on February 20, 2006 to include a specific list of documentation that must be reviewed before a decision can be made. (Attachment, "Clinical Review Policies and Procedures, Clinical Review of Claims, Sections C and D".) This will ensure that complete, relevant and appropriate documentation is obtained and reviewed before a final decision is made for an out-of-network claim. The policy and procedure was revised to clearly state what information (clinical and subjective entries) in the medical records will be used to determine the existence of an emergency medical condition as defined in the member's Evidence of Coverage. The staff will be in-serviced on the revised policies and procedures on March 8, 2006. • Clinical Review has a current practice in place to perform an annual inter-rater reliability audit of all staff involved in the clinical decision making. A description of the inter-rater audit is included in the Clinical Review Policies

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		and Procedures, under the section titled, Quality Improvement. The Clinical Review Policies and Procedures were revised to include an inter-rater reliability audit between Clinical Review physicians and Health Plan Regulatory Services physicians. The inter-rater reliability audit will be performed quarterly, using a random sample of denied non-appealed claims. The 1st audit will be conducted in July, 2006 for cases processed during the 2nd quarter of 2006. This process will ensure that physicians in Clinical Review and Health Plan Regulatory Services are utilizing a consistent approach when reviewing claims. The decisions will be also be audited externally by an independent external physician on a semi-annual basis. A description of the inter-rater audit is included in the Clinical Review Policies and Procedures, under the section titled, Quality Improvement. (Attachment, "California division Health Plan Clinical Review Department Policies and Procedures") • The monthly grievance overturn report will be jointly reviewed by the management team in Clinical Review, Health Plan Regulatory Services Investigation and Response Unit and the CCA Compliance Team. Analysis will be conducted to determine the specific reason(s) for the overturned grievance cases. The results of the analysis will be tracked and trended to identify opportunities for process improvement and reported to the members of the monthly compliance meetings and quarterly executive claims review meetings. The Plan's has identified the existing process that supports its effort to consistently apply the Emergency Medical Condition standard at the initial claims review.

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		• Claims examiners, as well as the Clinical Review staff, will continue the practice of authorizing payment for an out-of-network claim based on the medical records, ICD9 codes, and/or billed procedures or other charges. A member statement that may have been included with a member submitted claim will also be used to authorize payment for an out-of-network claim. This practice is described in the Clinical Review policies and procedures, under the section titled, "Pay Rules." • The Medical Director in Special Services Clinical Review is responsible for ensuring that all clinical and non-clinical staff is updated in the interpretation of the emergency medical care benefit. The Medical Director's scope of responsibility was expanded to include quarterly discussions with all physicians participating in the review of commercial member grievances regarding any changes in the approach to the application of the Emergency Medical Condition and the emergency care benefit. Please refer to the Attachment, "California Division Health Plan Clinical Review Department Policies and Procedures, under the subject "Quality Improvement." <u>Responsible Party:</u> • Elizabeth Moorehead (Director of Regulatory Compliance, CCA) • Sheila Tucker (Director of Clinical Review) • Lydia Sweatt (Manager of Special Services Clinical Review) • Bruce Locke, MD (Medical Director Clinical Review) • Christie Larner (Director, Regulatory Investigations and Response Health Plan Regulatory Services)